

THE DIVISION OF HEALTH OF MISSOURI
FILED DEC 11 1957 STANDARD CERTIFICATE OF DEATH

State File No. **43038**
Registrar's No. **2926**

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|---|--|---|--|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 317 | | PRIMARY REG. DIST. NO. 300 | | Registrar's No. 2926 | |
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo. b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy | | c. LENGTH OF STAY (in this place) 2 wks. | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Normandy Osteopathic | | | | e. STREET ADDRESS (If rural, give location) 4808 A Bessie | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Joseph | | b. (Middle) Gregory | | c. (Last) Danaher | | 4. DATE OF DEATH (Month) (Day) (Year) 11 25 57 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 11-17-97 | |
| 9. AGE (In years last birthday) 60 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Pressman | | 10b. KIND OF BUSINESS OR INDUSTRY Western Waxide | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME William Danaher | | 13b. MOTHER'S MAIDEN NAME Alice Fitzgerald | | 14. NAME OF HUSBAND OR WIFE Loretta Danaher | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1918-Navy | | 16. SOCIAL SECURITY NO. 492-03-5734 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Madame Loretta Danaher 4818 A Bessie | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Medullary Lesion ANTECEDENT CAUSES: Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Septic Cholangitis DUE TO (c) Myocarditis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs 90-120 days 6 months | |
| 19a. DATE OF OPERATION 11/19/57 | | 19b. MAJOR FINDINGS OF OPERATION Cholangitis; Duodenal Ulcers (old) | | | | 20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I attended the deceased from 11/14/57 , 19__, to 11/25/57 , 19__, that I last saw the deceased alive on 11/25/57 , 19__, and that death occurred at 7:30 a.m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) H. H. Hoermann, D.O. | | | | 23b. ADDRESS 8700 Riverview Blvd. | | 23c. DATE SIGNED 11/26/57 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 11-29-57 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cem. | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| DATE REC'D BY LOCAL REG. 11-27-57 | | REGISTRAR'S SIGNATURE Herbert B. Donahue | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.J. Dannelly - St. Louis, Mo. | | | |

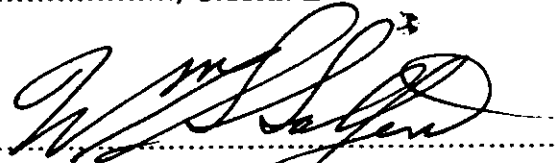
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Landa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.